

Cognitive-Behavioral Therapy Effective for OCD

BY MICHELE G. SULLIVAN
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TORONTO — Childhood obsessive-compulsive disorder often responds very well to an intense course of cognitive-behavioral therapy with an emphasis on exposure and response prevention.

Unfortunately, up to 5 million patients in the United States and Canada are not receiving complete treatment for their OCD, because few clinicians are trained in this kind of therapeutic approach, Eric A. Storch, Ph.D., said at the joint annual meeting of the American Academy of Child and Adolescent Psychiatry and the Canadian Academy of Child and Adolescent Psychiatry.

"There's definitely a lack of training in this area," said Dr. Storch of the University of Florida, Gainesville. "Some therapists are also reluctant to even try it. But to the question, 'Does CBT work for OCD?' the answer is a resounding yes."

Three randomized controlled trials have shown the effectiveness of exposure and response prevention (ERP) techniques, he said. A 1998 trial included 22 children aged 8-18 years who were randomly assigned to ERP or clomipramine for 12 weeks. Those on ERP showed an average improvement of almost 60%, compared with a 33% improvement for those in the medication arm (J. Am. Acad. Child Adolesc. Psychiatry 1998;37:1022-9).

One of the 2004 studies randomized 77 children aged 7-17 years to individual or group cognitive-behavioral family-based therapy or a 4-6 week wait list. The children in both therapy groups improved similarly, with symptom reductions of more than 60%, while symptoms in-

creased slightly in the wait-list group (J. Am. Acad. Child Adolesc. Psychiatry 2004;43:46-62). A study of 48 patients aged 8-19 years old by several of the same researchers also found that treatment gains were maintained; 70% of subjects in individual therapy and 84% in group therapy were diagnosis free at a follow-up of 12-18 months (J. Am. Acad. Child Adolesc. Psychiatry 2005;44:1005-14).

The Pediatric OCD Treatment Study, also published in 2004, randomized 112 children aged 7-17 years to CBT alone, sertraline alone, combined CBT and sertraline, or placebo for 12 weeks. Rates of remission were 54% in the combination group, 39% in the CBT group, and 21% in the sertraline only group (JAMA 2004;292:1969-76).

Dr. Storch is now conducting his own trial. It includes 31 children aged 7-17 years, who were randomized to intensive CBT (14 sessions in 3 weeks) or 14 weekly CBT sessions. Preliminary findings indicate a greater improvement in the intensive CBT group (94%) than in the weekly group (67%).

Up to 80% of OCD has a childhood onset, Dr. Storch said. Without treatment, these children face a life of disruptive thoughts and behaviors. "It doesn't re-

mit," he said. "There is tremendous impairment: Grades drop, kids get picked on, and the family is affected."

In OCD, a neutral object becomes associated with increasing anxiety, he said. The patient develops rituals to decrease his anxiety level. "The rituals start small, but they grow exponentially because the

patient becomes tolerant to them. In order to maintain the same reduction in stress, the rituals have to become more complex."

Exposure and response prevention therapy aims to decrease the anxiety associated with the thought by exposing patients to whatever provokes the associated ritual, while asking them to refrain from engaging in the ritual. "Not do-

ing so causes the anxiety to gradually and naturally decrease," Dr. Storch said.

Each ritual must be extinguished completely before moving on to the next. It's best to start out with the smallest one and then tackle the more difficult ones, he said. "We'll say, for example, 'Don't check the faucet when you go out, but you can still do all your other things.' The key, however, is you can't progress until this one thing is mastered."

Although actually refraining from the ritual is most effective, patients can also

practice refraining in their imaginations. "Duration and frequency are important. If you can expose them for long periods frequently, you will have better results."

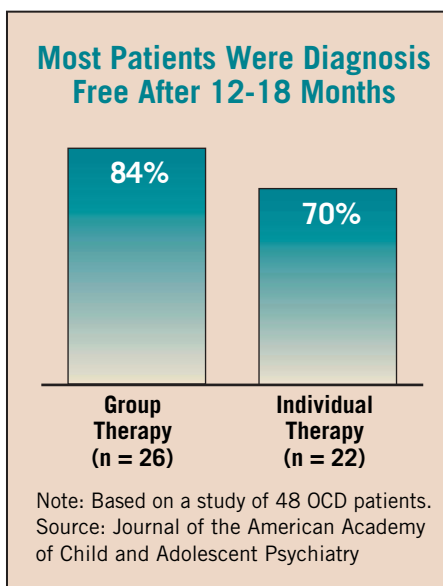
Cognitive restructuring is another component of the treatment, Dr. Storch said.

"OCD arises from inaccurate beliefs about stimuli. The aim is to teach the patient to identify and correct anxiety-provoking thoughts that motivate compulsive behaviors—to help them identify the thought and then appraise it accurately," he explained. Common cognitive errors are doubt ("I can't remember if I locked my door"); fusion of thought and action ("If I think about something, it must mean I want to do it"); catastrophic thinking ("I'll get sick and die if I go near sick people without washing up"); and responsibility ("If my mom gets cancer, it will be my fault").

Dr. Storch addresses these cognitive errors by asking patients to keep a thought record. The document consists of recording the action, the thought that came with it, the accompanying anxiety or fear level, and the resulting ritual.

He then asks the patient to "talk back to the OCD" by writing logical thoughts that could counteract the illogical assumptions. "The talk back section might include thoughts about the actual evidence of getting sick from using a public bathroom, for instance, or an observation that friends use public restrooms and don't contract diseases from them and facts about how diseases are transmitted."

Families should be included in the therapeutic process for optimum reinforcement, he said. "We want to teach parents to implement everything we do 24 hours a day, 7 days a week." ■



More Data Support Link Between Sudden-Onset OCD, Strep

BY MICHELE G. SULLIVAN
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TORONTO — A sudden, severe onset of childhood obsessive-compulsive disorder with tics should prompt a throat culture for group A streptococcus, Dr. Tanya Murphy said at the joint annual meeting of the American Academy of Child and Adolescent Psychiatry and the Canadian Academy of Child and Adolescent Psychiatry.

Considerable controversy surrounding the issue persists. But enough evidence exists to suggest a link between acute strep infections and the onset of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), said Dr. Murphy, director of the Child Tic and Anxiety Disorder Clinic, University of Florida, Gainesville.

"There are different opinions on what to do and what to believe," she said. But a throat culture is an easy, non-invasive method of exploring the possibility of an infectious link.

The OCD that children develop with a strep infection looks quite different from the chronic course usually observed. "The onset is sudden and dramatic," she said. "The illness follows an episodic or sawtooth course that's marked by changes in strep titers. During exacerbations, you will see a positive culture or rising titers, and during prolonged remission, the titers will fall."

The OCD is often accompanied by choreiform movements, tics, and comorbid symptoms, including emotional lability, separation anxiety, nocturnal enuresis, and

change in school performance. Some children with PANDAS may not have a positive strep throat culture, however. In these cases, serial strep titers may give evidence of a subclinical infection. If strep is present, children should take a full course of antibiotics and return for a repeat culture shortly after the antibiotic is completed.

PANDAS appears to be at the center of a convergence of three factors, Dr. Murphy said: a group A strep infection, genetic predisposition (familial OCD, Tourette's syndrome, or rheumatoid fever, including Sydenham's chorea), and an environmental stress factor such as a central nervous system injury or coinfection. The incidence peaks at ages 5-12 years—the same ages in which strep infections peak.

Dr. Murphy presented the results of a prospective study of 25 children, aged 7-17 years, with typical OCD and tics. The children were assessed every 6 weeks and had at least 6 consecutive assessments; strep titers were taken at each visit. Fifteen children exhibited an episodic or sawtooth disease course. Almost 60% of the episodic group had elevated group A strep titers on all of their visits, while 60% of the steady disease course group had no elevated titers at any time, suggesting that those with a PANDAS-like course have had more frequent undetected strep infections or prolonged immune reaction to past strep infections.

Those with episodic disease were also more likely to have exacerbations in the fall and winter, concurrent with the seasonal rise in strep infections. The children in the episodic group were more likely to be male (67% vs. 30%)

and have attention-deficit hyperactivity disorder (73% vs. 40%), compared with those in the steady course group.

"Unlike its namesake, however, PANDAS isn't all black and white," Dr. Murphy said. There have been few reports that antibiotics for children suspected of having the disorder improved their OCD or tic symptoms. Definitive studies still need to be conducted to clarify the impact of antibiotic treatment on symptoms.

In a 2005 study, 23 children with PANDAS received either azithromycin or penicillin prophylaxis. The drugs decreased additional strep infections and neuropsychiatric symptom exacerbations (Biol. Psychiatry 2005;57:788-92).

In 2002, a prospective study found that children with PANDAS experienced OCD symptom resolution after receiving antibiotics at the sentinel OCD episode (Arch. Pediatr. Adolesc. Med. 2002;156:356-61).

An early clinical trial involving the use of prophylactic penicillin for PANDAS revealed no conclusive evidence that the antibiotic reduced clinical exacerbation. However, the sample size was small (37 subjects), the treatment arm was brief, and the lack of efficacy may have been attributable to the failure of antibiotic therapy to eliminate streptococcal colonization in the patients enrolled in the study, Dr. Murphy said. Since then, investigators have reported improvement in neuropsychiatric symptoms with antibiotic treatment in patients presenting with PANDAS. Difficulties with study design and the small sample size of these early antibiotic trials limit the clinical influence of their findings. ■